

# HEALTH INSURANCE AND OPTIONAL STATUS CHANGE



**Check One:**  
 Active Member  
 Retired Member

**Public Education Employees' Health Insurance Plan**  
**P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150**  
**334-517-7000 or 877-517-0020**  
**Web site: [www.rsa-al.gov](http://www.rsa-al.gov)**

This form is to be used to make changes to your existing insurance coverages and to certify or change your tobacco status.  
 In lieu of completing and mailing this form, you can make your changes online using the Web site above.  
**Please print and complete the front and back of form.**

### PEEHIP Subscriber Information

*Name must be entered as shown on Social Security card. All address changes must be made on the Retirement Systems of Alabama Address Change forms.*

Social Security Number ____-____-____	First Name	Middle Name/Initial	Last Name
Date of Birth ____/____/____	Daytime Phone ____-____-____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Legally <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No			

**Have you or your spouse used tobacco products within the last 12 months?\***

*\*This information is required for enrollment.*

*Please complete the following fields if you have changed your name or changed employers.*

Previous Full Name (First, MI, Last) / Previous School System	New Full Name (First, MI, Last) / New School System	Date of Employment Transfer ____/____/____
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### PEEHIP Coverage Information

*For an effective date of coverage other than October 1, there is a 270 day waiting period for pre-existing conditions unless proof of previous coverage is received and approved by the PEEHIP office. The PEEHIP office will not automatically cancel any coverage(s). All cancellations must be indicated on the Health Insurance Status Change form.*

Coverage Type: (Only check boxes requiring a change)	PEEHIP Hosp/Med	PEEHIP Supplemental	VIVA HMO	(Optional plans must be all Single or all Family)			
				Cancer	Dental	Indemnity	Vision
Change from Single to <b>Family</b> Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Add dependent(s) listed below to Family Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancel Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change from Family to <b>Single</b> Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancel dependent(s) listed below from Family Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Requested Effective Date** \_\_\_\_/\_\_\_\_/\_\_\_\_ (Date must be included or form will be returned)  
*Note: You will be billed for prorata premiums or for premiums that are not deducted.*

### Reason for Status Change(s)

*Changes cannot be processed without the appropriate documentation as explained in the member handbook for starred (\*) items. Active members must have an IRS qualifying event to cancel their hospital medical or change their coverage outside of Open Enrollment because their premiums are pre-taxed.*

<input type="checkbox"/> Adoption of a child* (need adoption papers) <input type="checkbox"/> Birth of a child* (need birth certificate) <input type="checkbox"/> Death of spouse/dependent* (need death certificate) <input type="checkbox"/> Dependent age 19 or older changing student status* <input type="checkbox"/> Dependent loss of coverage* (need proof of loss of coverage) <input type="checkbox"/> Divorce/Annulment* (need divorce decree)	<input type="checkbox"/> Legal custody of a child* (need custody papers) <input type="checkbox"/> Marriage* (need marriage certificate) <input type="checkbox"/> Marriage of dependent child <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Termination of spouse/dependent employment* <input type="checkbox"/> Commencement of spouse/dependent employment* <input type="checkbox"/> Medicare/Medicaid entitlement* (need copy of card)
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**Date change occurred (Required)** \_\_\_\_/\_\_\_\_/\_\_\_\_

### Dependent Information (only required for family coverage)

*Note: Social Security Number is required for all dependents. Name must be entered as it appears on the Social Security card. Enrollments cannot be processed without the appropriate documentation as explained in the Member Handbook for any starred (\*) items.*

Name of Dependent (First, MI, Last)	Social Security Number	Date of Birth	Relationship to Subscriber	Sex	Marriage Date
			<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Common-Law*	<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____
			<input type="checkbox"/> Biological <input type="checkbox"/> Adopted* <input type="checkbox"/> Step* <input type="checkbox"/> Other*	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student* (must complete other side) <input type="checkbox"/> Handicapped*
			<input type="checkbox"/> Biological <input type="checkbox"/> Adopted* <input type="checkbox"/> Step* <input type="checkbox"/> Other*	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student* (must complete other side) <input type="checkbox"/> Handicapped*
			<input type="checkbox"/> Biological <input type="checkbox"/> Adopted* <input type="checkbox"/> Step* <input type="checkbox"/> Other*	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student* (must complete other side) <input type="checkbox"/> Handicapped*
			<input type="checkbox"/> Biological <input type="checkbox"/> Adopted* <input type="checkbox"/> Step* <input type="checkbox"/> Other*	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student* (must complete other side) <input type="checkbox"/> Handicapped*

**Student Verification** (only necessary to complete for dependent children **between the ages of 19 and 25**)*If full-time student, list dependent's first name and university, college, or accredited vocational school.*

Name	School	Term Attending	Hours Enrolled
Name	School	Term Attending	Hours Enrolled

**Combining of Allocations***Allocations can only be combined at certain times and only if your spouse is independently eligible for PEEHIP.*I wish to  transfer  receive the state insurance allocation  to  from my spouse.

Spouse's Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Effective Date of Combining Allocations: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Additional (Non-PEEHIP) Group Health Insurance Coverage Information**This section must be completed if the member elects the PEEHIP Supplemental Plan **or** if the member or dependent(s) have other group health, dental, or vision coverage currently in effect.

Name of Insurance Company	Policy Number
Name of Policy Holder	Relationship to Policy Holder
Policy Effective Date ____/____/____	Type of Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family

**Medicare Information**

This section must be completed if you or your dependents are eligible for Medicare.

If a member or dependent is under age 65, the PEEHIP office must receive a photostatic copy of the Medicare card before the premiums can be reduced.

Name	Medicare Card Number
Check the Medicare Part(s) for which you are eligible: <input type="checkbox"/> Part A-Effective: ____/____/____ <input type="checkbox"/> Part B-Effective: ____/____/____ <input type="checkbox"/> Part D*-Effective: ____/____/____	
Name	Medicare Card Number
Check the Medicare Part(s) for which you are eligible: <input type="checkbox"/> Part A-Effective: ____/____/____ <input type="checkbox"/> Part B-Effective: ____/____/____ <input type="checkbox"/> Part D*-Effective: ____/____/____	

*\*If you are enrolled in Medicare Part D, you are not eligible for the PEEHIP prescription drug plan coverage.***Retiree Other Employer Information**

The following fields must be completed by PEEHIP members who retire after September 30, 2005.

Pursuant to Act 2004-649, if you retire after September 30, 2005, and become employed by another employer and the other employer provides at least 50% of the cost of single health insurance coverage, you are required to use the other employer's health benefit plan for primary coverage. You may enroll in the PEEHIP Supplemental Plan or the PEEHIP Optional Plans.

Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please complete the employer information below.		
Employer	Date of Employment ____/____/____	Last Day Employed ____/____/____	
Mailing Address	City	State	ZIP Code

Are you eligible for health insurance with your employer?  Yes  No  
If yes, will your employer pay at least 50% of the cost of single health insurance coverage?  Yes  No

Name of Insurance Company	Policy Effective Date ____/____/____	Type of Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family
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**PEEHIP Subscriber Certification**

Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. I further understand that there is mandatory utilization review and I do hereby release any information necessary to evaluate, administer and process claims for benefits to any person, entity or representative acting on the Plan's behalf. I also agree to periodic tobacco usage testing and agree to notify the PEEHIP office if my or my spouse's tobacco status changes or if my employment status changes. I also agree to have premiums deducted from my retirement check or paycheck for any prior months that are due but were not deducted at the proper time.

Employee Signature \_\_\_\_\_ Date Signed \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please mail the completed form to the address located on the front of this form.**